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The role of ‘embeddedness’ in the delivery of integrated children's services

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Abstract

How integration of statutory and voluntary children’s services can occur is the focus of this paper and is theorised using ‘embeddedness’ theory. The paper considers strategies utilised by practitioners in integrated Children’s Centres in one English Local Authority to engage children and families identified as requiring enhanced (targeted) services. The service comprised free early education for two year olds and bespoke packages of family support aimed at improving parenting practice, improved safeguarding and contributing to greater self-efficacy for parents and carers. The findings indicate the importance of, and often lack of, ‘embeddedness’ in local communities and within statutory and non-statutory services and propose this as a barrier to the most disadvantaged families participating in services.

Key Words

Collaboration; Children’s Centres; embeddedness; social capital; joint working

1. Introduction and background

Hailed as a ‘radical cross-departmental strategy to raise the physical, social, emotional and intellectual status of young children’ (Glass, 1999, p.257) *Sure Start Local Programme* (SSLP) Centres were introduced in 1998 by the New Labour government in England as part of their agenda to tackle child poverty and social exclusion. The SSLPs were initially established in geographical districts according to the levels of deprivation within their areas. *Every Child Matters: change for children* (DfES, 2004) proposed a switch from *Sure Start Local Programmes* to Local Authority controlled *Sure Start Children’s Centres* and a roll out of universal provisions across all areas of England; not just the most deprived. This marked an increase from 524 SSLPs to 3,631 *Sure Start Children’s Centres*¹ in 2010, although this number has reduced under austerity measures introduced since 2010 and most recent figures suggest a drop in numbers to 3,116- although it is unclear how many of these are due to mergers rather than closures (Education-Select-Committee, 2013). The Centres were intended to improve the life chances of children under four through early intervention. The Centres provide a range of core services including early education and care, family support, primary community health services and outreach services (Clarke, 2006). They recognise the importance of positive family relationships and parenting behaviours in child outcomes and the need to provide social support for isolated and vulnerable families (Ghate & Hazell, 2002). Child outcomes are viewed increasingly as embedded within family circumstances with an emphasis on Centre practice that facilitates the development of parent’s informal networks (Winkworth, McArthur, Layton, Thomson, & Wilson, 2010).

This study took place in 2011, since when substantial changes in Children’s Centres have been evident. In particular the way in which Government funding for early intervention is provided has changed; moving from the Department for Education (DfE) to the Department for Communities and Local Government (DCLG). Arguably this emphasises the role of local authorities in tailoring services to meet local needs, but it also ‘breaks the direct link between the Department for Education and children’s centres’ (Education-Select-Committee, 2013, section 136). In particular this has

¹ Commonly referred to as ‘Children’s Centres’

allowed for a reduction of ring fencing of funding to Local Authorities, with concerns about the lack of protection of funding for early intervention. This concern has now been replaced with a worry from the Local Government Association (LGA) that the increase in provision for disadvantaged 2-year olds which this paper focuses on, which is within the ring-fenced Dedicated Schools Grant, is at the expense of other early intervention expenditure and that a further fall in the number of Centres being funded will occur (LGA, 2013). This is emphasised in a very recent survey of 879 Children's Centres in England which reports concerns by 57% of managers that they fear additional budget cuts in 2015 (4Children, 2014) and the report authors assert that there has been an overall 20% reduction in funding in the early years in the last three years.

1.1. Early education

The specific effects of early years education on children's cognitive and social and emotional outcomes have been demonstrated by the EPPE² and REPEY³ studies in the UK (Siraj-Blatchford, Muttock, Sylva, Gilden, & Bell, 2002; Sylva, Melhuish, Sammons, Siraj-Blatchford, & Taggart, 2004; Sylva, Melhuish E., Sammons, Siraj-Blatchford, & Taggart, 2010). 'Quality' in early year's education was identified in these studies, incorporating process issues - factors relating to programmes, professional values and relationships, and pedagogy; structural elements – for example, staffing and assessment; as well as issues relevant to partnerships with parents and families (Pugh, 2010). The relationship between these factors is complex: some factors mitigating or intensifying the effects of others. We also believe that quality is enhanced if the organisation is embedded in local networks and this assertion is what this paper aims to examine. Knowledge of these factors outlined by Pugh (2010) has resulted in recent reviews: of curriculum in the early years (Tickell, 2012); qualifications and training of early years practitioners (Nutbrown, 2012) and a focus on the importance of early intervention to reduce inequalities, particularly in respect of the provision of early education (Allen, 2011; Field, 2010).

The literature confirms that the benefits of attending pre-school are particularly significant for vulnerable children who are more sensitive to the effects of quality.

² The Effective Provision of Pre-school Education

³ Researching Effective Pedagogy in the Early Years

Such claims resulted in pilot studies to provide early year's education and family support to the most vulnerable two year olds in some Local Authority Children's Centres (Smith et al., 2009; D. Watson, Cameron, & Aghtaie, 2011) where parents and practitioners have reported social, emotional, cognitive and developmental gains for children; particularly in speech and language development. The impact of early education for two year olds currently relies on small and localised data sets and there is no longitudinal data yet available on the long term impacts. Despite this lack of evidence, as recommended in the Allen review (2011) and legislated for in the *Education Act* (DFE, 2011) there is a UK government commitment to free early education for the 20% most disadvantaged two year olds across England in September 2013; with a government pledge to extend this to 40% of two year olds in September 2014 according to means testing of parents based on their receipt of state welfare benefits. Children are also eligible if they are looked after in public care or have a diagnosed special educational need or disability. Concerns about this development focus on the provision of high quality places for vulnerable 2-year olds, the impact on available places to other age groups and the apparently negative view of maintained nurseries in providing additional places held by the Government (Education-Select-Committee, 2013).

1.2. Engaging families

Whilst Children's Centre services could vary according to local need, the tenet of the 'core offer' was supposed to be met in all Centres; although the shift from SSLP to universal Children's Centres heralded a shift away from a discourse of support for children and families toward a focus on early education and early intervention (Lewis, 2011; Lewis, Cuthbert, & Sarre, 2011). Provision in Centres is diverse and influenced by a number of factors including the previous history of the organisation and the cultural expectations and local needs, as well as the staff expertise within Centres and their understandings of 'quality' (Cottle, 2011; Lewis, 2011; Lewis, Cuthbert, et al., 2011; Lewis, Finnegan, & West, 2011). Lewis *et al* (2011a) report that a lack of consistency in expectations for outreach work, staff qualifications and expertise and thresholds for the involvement of other specialist services have further added to the diverse nature of Centre's activities. There have been concerns raised that Centres focus on the deficits in parents with a continuum of 'hard-to-reach' families emerging

that include young parents and fathers, BME families and groups who have been notoriously difficult to engage with outreach services (Lewis et al, 2011a).

One perceived solution to the stigmatising impact has been to develop an ethos and practice in Children's Centres of co-production in respect of a more general public service trend to involving service users in the delivery, planning and evaluation of services (Clarke, 2006). It has been argued however, that co-production as an element of innovation in public services is often based on a manufacturing model where the 'consumerist' ideology hides the fact that the 'consumer' is actually a service user in need of support (Osborne & Brown, 2011). The original *Sure Start* policy made clear that services should be developed to meet the needs of local populations and should be appropriate to individual areas with strong community involvement. A study in Greater Manchester (Pemberton & Mason, 2008) highlighted that whilst engagement of parents in co-production of Centre services through parent forum and evaluations of activities was an ambition of SSLP's, the reality mirrored wider concerns about engagement; with patterns that reflected the lack of men, BME families, young and lone parents in shaping and defining what services were needed in the locality. Clearly without such involvement the domination of other voices in service delivery will mean that they are not necessarily tailored to the needs of the most disadvantaged families in the community and this further increases inequalities for families (Pugh, 2010). Small numbers of studies have reported parents' positive experiences of engagement in Centres but these have rested on individual settings that have specifically focused on building social capital networks through directly engaging parents in communities to develop existing 'bonding' capital into 'linking' and 'bridging' forms of capital that it is claimed increase feelings of empowerment (Bagley & Ackerley, 2006).

Integrating Children's Centre activities in local communities has been a challenge since their inception as SSLPs. This is particularly noted as an issue in literature that identifies poor communication with parents and a lack of visibility in the local neighbourhood (Avis, Bulman, & Leighton, 2007) as contributory factors. Several reports considered how SSLPs maximised access to services for children and families (Garbers, Tunstill, Allnock, & Akhurst, 2006). Often Centres used creative and innovative approaches to engage families including targeted publicity; the

identification of individual families with partner agencies and outreach strategies that addressed identified physical and emotional obstacles to access (Jupp, 2013; D. L. Watson, Aghtaie, & Turney, 2012).

The dissonance between statutory providers and SSLPs has also been widely reported particularly in the initial phases when SSLPs were targeting families based on poverty indicators as opposed to the professional discretion applied by statutory services, often working with the same families (Edgley, 2007). This has led to criticisms of the underlying philosophy of *Sure Start* which Edgley (*Ibid.*) suggests hampered any attempts to embed Children's Centres within existing statutory provision, particularly as many statutory providers believed that they should control services provided in SSLPs.

1.3. Integration and joint working

The underlying ethos of Children's Centres is one of collaboration across statutory and voluntary sectors (Clarke, 2006) involving social care, health and education (Anning & Ball, 2008; Anning, Cottrell, Frost, Green, & Robinson, 2006; Avis et al., 2007). There is an underlying assumption that integrated services offer a better means to combat the negative effects of poverty and disadvantage on children and families (Coe, Gibson, Spencer, & Stuttford, 2008; Pugh, 2010). These agencies would collaborate to offer a broad range of services and interventions including educational support, home visits, parenting support, healthy eating advice thus ensuring that these services were based on a shared philosophy and vision and common working practices (McInnes, 2007).

Integration is thought to lead to improved communication between agencies and, in the light of previous inquiries into child deaths, will prevent children 'falling through the cracks' between services and this ethos sits alongside a rationale that suggests that integration will lead to improvements in efficiency (Warin, 2007). A rapid review of international literature confirms the challenges of determining a link between outcomes for children and interagency working, but acknowledges that where there is evidence of the impact on children's outcomes these are largely positive in terms of improved access to services and a speedier response (Statham, 2011). Whilst the evidence for interagency working in children's services is limited, it has still become

a mantra in children's services in the UK (Morrison & Glenny, 2012). However, the shift to universal Children's Centres has arguably made it more difficult for integration of services and agencies (Anning & Ball, 2008) with many Centres reporting that relationships with other services are based on 'good will' and personal relationships, not on commitments to partnership working (Lewis et al, 2011a). Other research highlights the gaps in health knowledge of Centre practitioners and the wider challenges posed for integration of health services (Condon & Ingram, 2011; Raymond, 2009). A review of models of integrated health services for pregnant women, children and families reported effective communication mechanisms and professional relationships and boundaries as key areas of concern in collaboration (Schmied et al., 2010).

The apparent simplicity of working together in children's services neglects the complexities involved, making it difficult for front line practitioners to make sense of the multiple needs of children and families and find appropriate solutions. This complexity means that whilst an intervention may work with one family it may fail with another; or it may work for a while and then cease to work (Hood, 2012). Indeed as Hood (2012) claimed the managerial models of integrated working and the focus on risk and accountability have given 'little thought to the unpredictable dynamics that beset complex casework' (p.17). How integration of statutory and voluntary children's services can occur is the focus of this paper. In order to understand this we now turn to the theoretical framework that was utilised.

2. Embeddedness theory

Attempts to theorise the challenges faced by Children's Centres in meeting the demands of local communities have focused on the mistrust of parents who question the involvement of social services in seemingly universal provisions (Griffin, 2010) and the focus on children and families deemed to be at risk, as opposed to the wider community (Jack, 2005). Emphasis has been placed on the potential for Centres to build social capital in disadvantaged neighbourhoods (Bagley, 2011; Griffin, 2010) particularly in respect of 'bridging capital' (Putnam, 2000). Although as Bagley (2011) suggests the shifting policy discourse that has dogged *Sure Start*, has resulted in shifting power balances away from parents and multi-agency teams to local and

central control thereby undermining any claims to social capital, particularly for disadvantaged families. Furthermore, there are critiques that support services in poor neighbourhoods are often provided by ‘poverty industry professionals’ who are ‘disconnected from the local community’ (Jarvis, Berkeley, & Broughton, 2012, p.235) and where competition for funding between mainstream and Third Sector providers results in power differentials and poor interprofessional collaboration (Milbourne, 2009).

Social capital theory has also been used to understand the nature of professional relationships and the impact of policy on interprofessional working in children’s services (Forbes & McCartney, 2010). This focus has led some academics to map social capital and human capital matrices in order to understand the nature of capital ties between professionals and agencies involved in integrated children’s services (Forbes, 2011). In developing ideas of social capital and networks, Granovetter’s (1985) theory of ‘embeddedness’ in economic sociology is relevant; although it has been little applied in public service provisions, and absent from discussions of integrated children’s services. This appears to be a gap in the way we understand barriers to integrated working in Children’s Centres and seems a fruitful line of theorisation, particularly given that there is evidence that even in the absence of economic transfer that embedded behaviours appear to emerge based on individual relationship networks (Granovetter, 1985) such as trust and a shared commitment, particularly where there is ‘structural embeddedness’ apparent in relationships (Feld, 1997). Uzzi (1997) broadens the economic exchange theory of Granovetter to incorporate a theory of social structures that considers the closeness of ties in networks and the impact on motivations and behaviours in organisations which rests upon the relationships of individual actors (Uzzi, 1997).

This extends discussions of embeddedness from the importance of networked ties that facilitate organisational exchanges (and economic gain) to an understanding that is more social and relational in nature. The extent to which organisations are structurally embedded in networks has been explored in other public service research such as in mental health provision in the USA where ‘embeddedness in a network, is generally positively related to key social outcomes’ (Provan, Huang, & Milward, 2009, p.889). In particular the centrality of an organisation in the network is recognised as a key

feature of ‘positional embeddedness’ (Hsueh, Lin, & Li, 2010) where issues of trustworthiness, reputation and influence are dependent on the structural centrality of the organisation within the network (Provan *et al*, 2009). A less used component of embeddedness theory is that of ‘cultural embeddedness’ which ‘refers to shared collective understandings in the creation of strategies and objectives and influences the action, structure and procedures of organisations’ (Hsueh *et al*, 2010, p.1726) and may have utility in understanding integrated working in Children’s Centres.

3. Methods

This paper draws on data from a wider evaluation (D. Watson *et al.*, 2011). It focuses on an aspect of the data collected and has been theorised utilising embeddedness theory, although this was not the original aim of the study. The study utilised a qualitative approach using multiple methods (Johnson, Onwuegbuzie, & Turner, 2007) of semi-structured interviews, focus groups and observations in a convergent concurrent design where the different data sets were collected concurrently, but converged at the point of data analysis (Guest, 2013). Fieldwork was completed in 10 Children’s Centres in one English city in 2011. Given that the Coalition government’s austerity measures were initiated in 2010 this was a time of considerable uncertainty for Centres with budgetary reductions and possible merges and closures of services threatened.

The Centres were selected by the Early Year’s team in the Local Authority and were chosen to represent the diversity of provision across the city; all were either Phase 1 or Phase 2 Children’s Centres⁴ and provided enhanced services for two year olds. All Centres offered early education for children under 4-years, and a range of family support including targeted provisions such as structured parenting programmes, PEEP⁵ programmes (an evidence-based programme focusing on everyday play and learning opportunities) and universal ‘Stay and Play’ drop in sessions. In one Centre there was a specialist toy library for disabled children; one was a specialist assessment centre for young children with disabilities and several provided contact services for children and families in the public care system. Most Centres provided access to

⁴ Phases denote areas of greater socio-economic disadvantaged with Phase 1 being established first in areas of highest deprivation.

⁵ Parents Early Education Partnership

family learning sessions, careers advisors and sign posted families to external services supporting alcohol and substance misuse, domestic violence, mental health and employment. The majority of the Centres also provided outreach in the form of home visits to enable play sessions with children and some had health professionals co-located on the Centre site (health visitors or speech and language therapists) -but this was not the norm.

In each Centre parents/ carers of children provided for by the enhanced two year old service were interviewed as well as staff based there. The team also completed an observation of one organised family support session which identified families were accessing. Focus group interviews were also conducted with family support workers from centres that did not participate in the main phase of data collection. This paper only reports data collected from interviews with professionals.

Interviews were completed with a Centre manager, or deputy, at each of the 10 Centres as well as family support workers. A total of 22 professionals were interviewed and there were at least two interview participants from each setting. Interviews focused on the nature of family support within the setting; the process by which children and families were referred into the enhanced provision scheme; barriers and facilitators to engagement and the outcomes for families and children. Interviews were digitally recorded and transcribed in full.

Data was analysed iteratively whereby transcripts were read in detail and commonly occurring codes elicited and grouped together as overarching themes using a general inductive analysis approach (Braun & Clarke, 2006; Thomas, 2006). A general inductive approach is also useful in evaluative studies where evaluators wish to describe actual programme effects as opposed to just planned effects (Scriven, 1991). Key themes to emerge across the interview data with practitioners were: *Child outcomes, Supporting Families, Barriers to Engagement, Practice Concerns, Interprofessional and Interagency working* and *Referral Processes*. Given the space available here and the focus of the paper, data will be presented only from the *Interprofessional and Interagency* theme that emerged from data analysis. The other themes are reported in the project report (D. Watson et al., 2011).

Ethical review for this project was provided by The School for Policy Studies, University of Bristol Research Ethics Committee. The research conformed to established ethical practice (E.S.R.C., 2012) in respect of informed consent, anonymity, protection from harm and data storage. Each Centre was assigned a unique number which are used to present the data in this report and protect the anonymity of participants who are not identified separately in settings when there was more than one participant from a Centre.

4. Data Presentation and Discussion

Although the main focus of the study was to evaluate the implementation of the enhanced provision programme, many participants reflected on the importance of joint working in relation to their general work, as well as in relation to the enhanced provision programme. The presentation that follows focuses on data from within the *Interprofessional and Interagency working* theme and emphasises collaboration and joint working through the statutory actors involved (health and social work professionals); a focus on joint work with voluntary and other agencies; and the final section draws across the data to explore the embeddedness of Centres in their local communities as this seemed to be the clear point at which evidence of embeddedness was apparent. Embeddedness in work with health professionals and social workers was limited to particular relationships and strongly mitigated by the budgetary and policy changes that were starting to occur in the sector. The data presentation then concludes by drawing out examples where we believe there is evidence of embeddedness occurring in the joint working relationships.

4.1. Health professionals

Collaboration with health colleagues was frequently discussed by Centre professionals who noted a range of services that they worked with including those in: mental health; speech and language therapy, drug and alcohol services and occasionally general practitioners. Not unexpectedly the services most frequently discussed were health visiting, midwifery and speech and language therapy. In a UK context midwives are professionals providing care to women during pregnancy and birth and in the period immediately following birth to support with breast feeding and early infant care. They are regulated by the Nursing and Midwifery Council (NMC) established in 2002 following the Nursing and Midwifery Order (DoH, 2001). The

NMC sets standards and duties of practice (NMC, 2012) which define the role of qualified nurses and midwives and includes public health nurses such as health visitors. Health visitors have a duty to protect and promote the health and wellbeing of children in the early years (NHS England, 2014) and are key workers for children until the child is 5 years of age providing parenting education, support and ongoing health and development checks for young children in collaboration with mandatory health services, children's centres and nurseries. Discussion will focus on health visiting and midwifery as they illustrate our claims to embeddedness most clearly. The majority of participants noted the importance of health visiting services and participants from several Centres described having strong and enduring working relationships with health professionals based on collegial respect and trust (Schmied et al., 2010). This was particularly evident where health visiting services were currently, or had recently been, co-located:

Having health visitor's onsite is fantastic, especially if we have families who are hard to engage in any aspect of their enhanced provision (1).

Echoing themes identified in previous research (Anning et al., 2006), co-location was seen as an important component in ensuring smoother collaboration, specifically improving the nature and timing of information sharing about individual families. As one practitioner described:

I know people can do that over the phone, but it's much better to have them here. Yeah, it is amazing and I'm always popping in or they're popping in to see me to see if a child's been in, or if they can't get in to see a child, or, you know, check their health, they can come down cause they always come to the day care, they can come in and pounce on the parents as they come in the door (1).

Health visitors were not however routinely based at Children's Centres in this city and this meant that strategies had to be developed to ensure effective collaboration. At one Centre we were told that workers regularly did joint home visits with health visitors and additionally described how 'we ring them and they ring us just to share and update progress on children' (8). A similar pattern was reported at another Centre

where it was noted that in the past a health visitor had always attended a baby group run there and would 'bring her scales every couple of weeks to weigh the babies' (2). Although this type of integrated practice had ended, staff described how they had maintained these links with health visitors who they could 'always get hold of' and, if necessary, the health visitor would contact the Centre 'if she's got some more information about a family, she rings in and lets us know and we record it, she's very good' (2). Although at times collaborative relationships were put under strain, one manager described how:

Although we have got a linked health visitor, we don't see her and that's not for us not trying to joint work with them, but they just haven't got the time to offer us any support (4).

Across the interviews there was a general view that changes to the health visiting service had impacted on the way they worked with individual families:

In the past health visitors had had more opportunity to get to know families in their local area and would come and know a huge amount about families, but they don't now, because they just don't have that contact with them that they used to (2).

This point was elaborated on by another practitioner who suggested that health visitors were focusing their efforts on those families most in need:

I think they've been very stretched in this area, and the level of need of the families they're working with has changed, and they're only working with the high end parents, and they're struggling is not the right word – they're spending their time focused on that (3).

Specific concerns about joint working in relation to the provision of the enhanced programme were identified. In particular the perceived reductions in the health visiting services were thought to be undermining the referral process for the enhanced programme:

Since the health visiting service has been cut, I just think, actually, there could be a whole load of families out there that we just might not know about because they're not getting the home visits, so their needs aren't getting identified (7).

At another setting we were told that in order to improve collaboration between agencies a health visitor had been allocated to:

All the high end child protection families, and so she puts in loads of referrals, but it's good that you know it's that one person that you ring if you've got a problem (3).

Across Centres participants perceived that the local health visiting services were 'overstretched and understaffed' 'and there have been posts unfilled' (8). This reflects wider concerns that the pledges made by the Coalition Government to increase the number of health visitors have not been met (Turnbull, 2014). Whilst under-staffing caused frustration in the Centres, this manager went on to argue that it was important to understand the context in which other professionals were working so that agencies and individual practitioners could maintain a positive relationship 'rather than trying to kind of, you know, just push tasks across to each other' (8). Significantly there was recognition of the importance of agencies identifying a shared aim (Warin, 2007), particularly when funding was being reduced and services had to rationalise and prioritise their work (Nelson, Tabberer, & Chrisp, 2011):

We're coming from a different area because there might be issues that you know, we see children in a different light within the setting. Whereas a health visitor will see them when they visit the Health Centre or if they've visited the home, so you have to work together and try and find out, you know what the common target is, what you're aiming for, for that child (8).

Overall, participants universally observed that health services were struggling to provide the range of services they had in the past. As one manager reported:

The services that are available are just getting smaller and smaller. I think what we are able to offer, you know is decreasing and the need, as always in an economic downturn is going up and up (5).

Fewer participants discussed the role of midwifery services but those that did recognised this relationship as key to the referral of new families into Centres and ‘critical to enabling families to access early support’ (Abdinasir & Capron, 2014, p.3). One practitioner described close and effective working links particularly in relation to working with young mums (10). Practitioners at another setting on observing a drop in the number of referrals, as well as a rise in the incidence of late referrals, had set up a regular meeting with the specialist midwife based at a local hospital ‘because she picks up the young teenage mums’ (1). The new system was reported to be working better, ensuring more timely referrals. Significantly the new system had been initiated by Centre staff, not the midwives and this may have implied that health services were withdrawing from some areas of work and leaving other agencies to manage the consequences. This apparent lack of an automatic system of sharing information between health and children’s centres echoes the recent findings of the report commissioned by *The Children’s Society* in England that found that ‘almost half of local authorities (46.5%) do not routinely share live birth data with children’s centres in their area on a monthly basis’ (Abdinasir & Capron, 2014, p.3)

Another Centre reported that they had ‘very difficult links with midwives’ (7) and illustrated what can happen when these services are not well co-ordinated:

One of our more vulnerable mums had a new baby and we – she suddenly disappeared, obviously had the baby. We saw her a couple of days later, she came to pick up her other daughter and we said “oh how’s it all going, dah dah dah” and because we’ve got a good relationship with her we sort of said “oh, you know, are you managing with your breastfeeding?” no she said, “they didn’t help me at all.” So it’s really hard for us because you missed, it was a missed opportunity and you can’t go back to it now.

Once again changes that were happening elsewhere in the wider context were affecting the work of Children’s Centres, in this instance undermining the potential to

improve long term wellbeing of children and families. In order for the Centre to offer breastfeeding support they had trained a worker, and this supports the claims that it is not necessary for fully trained midwives or health visitors to do this work (Ingram & Johnson, 2009) as long as there is some training available in order to address lack of breastfeeding knowledge amongst Centre staff (Condon & Ingram, 2011). This seemed to be an illustration of Centre embeddedness within statutory services where joint working practices become part of the normal pattern in delivering pre and post natal care.

4.2. Social workers

Despite social care services being universally perceived to be working under increasing pressure, most participants described how social workers were still able to support the work of Centres. At one site, for example, we were told that their lead social worker attended the *Common Assessment Framework*⁶ panel every other week and that they were ‘always available to ring up and we’ve got a good relationship with another one who rings us quite regularly’ (1). A similar pattern emerged at most settings.

At several Centres it was reported that contact with social workers had increased because of the complexity of the lives of some of the families they were working with. This meant that Centres at any one time might be working with a range of different social work teams including the assessment team, duty team, child protection team and fostering teams. This arrangement did not always seem to be efficient. Some practitioners told us they had ‘daily contact by email and phone’ with social work colleagues (8). To simplify this relationship the Centre had negotiated, and was now paying for, regular meetings with a social worker, although there were already concerns about how this new arrangement would continue to be funded. At Centre 3 practitioners also perceived that social work services were stretched and that they were working with much more complex cases than they had in the past. As one practitioner described ‘I think they’re so busy and their criteria have changed. Social care seem to be working with the serious risk’ (3) and this placed pressures on

⁶ The Common Assessment Framework is a key part of delivering frontline services that are integrated and focused around the needs of children and young people. It is a standardised approach used by practitioners to assess children's additional needs and decide how these should be met.

practitioners in the Centre who were balancing advocacy and family behaviour monitoring in respect of child protection concerns (Nelson et al., 2011). They went on to suggest that prioritising those most at risk had consequences for the other professionals involved in the care ‘it’s all cascaded down, they’re having to work much higher up and actually we are as a consequence’ (3). The ability of Centres to identify needs of higher-need families and remain a preventative service was a challenge expressed by many of the practitioners interviewed and there was evidence of the diversity of preventative orientations identified by Sheppard in his study of Centre managers (Sheppard, 2011).

4.3. Joint working with other agencies

Across the interviews we were told of a range of other professionals and agencies that Centre staff worked with, most of these were from health and social care, but not exclusively. These included specialist mental health services, Community Paediatricians, CAMHS⁷, Educational Psychology, a drugs project, SENCO’s⁸ and the Jobcentre, as well as voluntary organisations supporting parents of children with disabilities and national charitable organisations such as Shelter⁹. However the agency most frequently discussed in relation to joint working was Barnardo’s, a UK wide children’s charity.

The role of Barnardo’s *Community Family Link Workers* (CFLWs) were discussed more frequently than any other non-statutory service. Barnardo’s had until recently been commissioned by the local authority to provide a focused home visiting service to support families with complex needs including social isolation, drug and alcohol misuse or domestic violence. The Barnardo’s service was recognised to have been particularly broad in nature, not only would Barnardo’s workers visit families at home, but they would also support them to engage with groups and programmes run at Centres, often accompanying mothers to Centres. This flexibility was perceived to be particularly valuable for those families that might be isolated, for example mothers with mental health problems. Not surprisingly where the Barnardo’s service was thought to have worked best was at those Centres where *CFLWs* had been located in

⁷ Child and Adolescent Mental Health Services

⁸ Special Educational Needs Coordinators

⁹ a homeless charity

the Centres. This arrangement helped to ensure a greater degree of co-ordination with Centre activities and communication and showed a level of trust and collaboration that is unusual in respect of the relationship between mainstream services and community organisations (Milbourne, 2009) and is an example of embeddedness of children's services where the Barnardo's workers were seen to be an extension of the core service provision.

Whilst there was a clear divergence in opinions about the effectiveness of the Barnardo's service, most, but not all, participants were concerned about the implications of the funding ending. Several Centre managers were worried that they would not have capacity within their current workforce to pick up this work, and as a consequence one manager described how she was 'concerned that there's going to be little pockets of families out there that we don't get to' (7). This concern was shared by many, for example one practitioner commented that staff at their Centre did not have the expertise to perform the same role:

- . And that's back to that expertise again, because the role that they were fulfilling was a very skilled role. And across the board, in people's homes, on a regular basis, and we don't have the capacity or the expertise to do that, but I think there's an expectation that Centres will pick that up (10).

Another practitioner described how they were providing 'a lot of the settling in with families at nursery which is where Barnardo's would have done it before' (3). The discontinuation of the *CFLW* scheme was also discussed in relation to the enhanced provision programme. We were told that families built up strong bonds with *Workers* and 'they would bring them to the group and introduce them to the next stage. But that's kind of missing in a way now' (3).

Increasingly settings were feeling stretched to meet the demands of one-to-one and additional home visiting work with families who were not ready to come into groups or who had disabilities, chronic illnesses or mental health problems that precluded their attendance at the Centre. The importance of replacing the home visiting play-based style of working that Barnardo's workers had engaged in was emphasised by settings that took treasure baskets and story sacks out to homes. But it was felt that

this work could barely replace the one-to-one and long term service that Barnardo's workers had been able to offer vulnerable parents.

4.4. Embeddedness in local communities

Analysis of the data suggests that one of the factors that appeared to influence whether or not enhanced families engaged with Children's Centres was the extent to which the Centre itself was embedded in the local community. Those Centres that reported being able to reach families in need, were often those that during the course of our interviews described having well developed links and presence in the local community in a number of ways. For example at one Centre (5), a practitioner told us that they regularly held sessions such as *PEEPs* and *Dreamtime*¹⁰ at baby groups in local health centres. Although resource intensive, these sessions enabled practitioners to reach families who they may not have known about, or been in regular contact with. By holding the sessions in local health centres they also reinforced the message that Centres provided universal services; thereby helping to reduce any perceived stigma. Practitioners from several Centres described being involved in local events for example running a stall at a local community fete, running school holiday Play Days in local parks or making links with local church and other community provided toddler groups. Taking services outside of the Centre buildings may also mitigate against individual reactions to the material space within which parenting and family support services are usually delivered, and which may hold particular emotional reactions for some families (Jupp, 2013). Being embedded in the local community meant that local people might hear about the Centre through a variety of different avenues and might therefore be more willing to access services if, as one practitioner said, 'people see you and they know your face' (9). As one Centre manager described 'it's about, you know, getting ourselves out into the community and reminding people we're here' (5).

Additionally, being embedded in the local community meant that Centres were able to draw on these links to offer different types of experiences or programmes to families. Practitioners at one Centre described how families visited a local college to watch a student show; whilst another told us how they had invited a local community healthy eating project to run cookery sessions with parents (7). Similarly, several Centres had

¹⁰ Structured group activities focusing on playing together

invited the local Fire Service to run sessions about fire safety in the home. In this way, practitioners were engaging in what Jupp (2013) describes as ‘*creative capacities* to act in the spaces in between and across different kinds of contradictory knowledge’ (p.13, *emphasis in original*). Taking services out to the community spaces also made them more accessible to families, which, it is argued, helps to embed the service in the community it seeks to serve (France, Freiberg, & Homel, 2010). Such an approach demonstrates respect for the resources of the community network and challenges individualised and deficit views of families (Bagley & Ackerley, 2006) and reflects the original ambitions of the *Sure Start Children’s Centres* (Edgley, 2007; Pemberton & Mason, 2008). Having contacts in the wider community also meant that Centres could put families in touch with other organisations, for example several practitioners told us that they had good links with toddler groups run in local churches so that they could ‘signpost families to them’, as well as having links with the local *Neighbourhood Trust* who ran adult learning courses (4).

Coe *et al* (2008) confirm the view that engaging ‘hard-to-reach’ families, such as those receiving the enhanced programme will not be successful if based on a one-off effort. Like Garbers *et al* (2006) they recognise the need for Centres to develop a range of strategies as a means to engage these families. This view was supported by our own analysis: Centres that reported that enhanced families engaged with services were those that demonstrated some sort of embeddedness within the local community – with a range of outreach activities and communication strategies in evidence. Like Coe *et al* (2008), the befrienders service, or in this case, Barnardo’s service, was key to this process of helping families, often mothers with mental health difficulties, overcome the effects of social isolation. This appears to operate as a form of *linking* social capital that ‘connects people who occupy different power positions’ (Forbes, 2011, p.580). The importance of a ‘link’ person to facilitate integrated services is also reflected in reports of *Sure Start Plus Advisers* who were established in SSLPs to support pregnant teenagers and young parents. These were individual workers operating out of SSLPs who it is claimed were advocates for young women and were able to operate across service disciplines to improve outcomes for the woman and her child (Malin & Morrow, 2009).

There is however, evidence in the data reported that the maintenance of social networks that facilitate good outcomes for children and families were not always reliant on individual relationships- rather that there was an element of ‘structural embeddedness’ (Feld, 1997) apparent in the joint working patterns within and across Centres. Thus, there is some evidence of ‘role embeddedness’ (*Ibid.*) occurring, where networks remain embedded despite individual staff changes because professionals understand the role of the contributing professionals and why it is advantageous to the whole enterprise of Centres to maintain these ties. This seemed to be an explanation for the moderated concern voiced over reduced contact with specific health visitors as there was an acceptance that regardless of the individual spoken to, their role was largely understood within integrated children’s service provision with the result that the importance of shared targets were prioritised over ‘relational embeddedness’ (Hsueh et al., 2010).

The importance of the centrality of the Centres in their networks (Hsueh et al., 2010) was also apparent and extends to their relationships with non-statutory and voluntary organisations (such as churches, toddler groups and *Barnardo’s CFLWs*) whom professionals and parents reported as integral to the experience within Centres. This is an interesting repositioning given the criticism that community based provisions have previously received (Avis et al., 2007; Pugh, 1998). Understanding the local community needs, concerns and interests appeared to drive innovative practice in some settings, but not all. This was noticeable in areas of higher cultural and ethnic diversity within the city where workers appeared to be more motivated to understand the cultural needs of the locality and could be interpreted as an example of ‘cultural embeddedness’ (Hsueh et al., 2010) where the ‘cultural, gender, and socioeconomic contexts’ (Waldegrave, 2009, p.85) within which services were provided were clearly understood. This community-based contextual knowledge and activity is also claimed to enable better safeguarding of children when services work with local communities (Jack & Gill, 2010).

The respect and trust placed in Centre staff by other statutory services such as social work and health professionals was also central to their ability to engage with enhanced families. This is particularly the case where statutory services are stretched and working at higher tier levels; but demands a level of training and expertise on the

part of Centre staff (Nelson et al., 2011) in order for them to be valued and achieve ‘positional embeddedness’ with those other professionals. Whilst we did not interview other professionals, there is evidence in the literature on professionals, particularly health professionals, valuing the contributions of Centre staff and adjusting their practice with families (Nelson et al., 2011).

5. Conclusion

Engaging families in integrated children’s services is often met with physical, financial, emotional, cultural and organisational barriers. These exist in the context of partnerships with parents and carers, and between agencies and individual professionals. Seeing these challenges within networks of relationships in the ways in which we have explored embeddedness in this paper; and understanding the central role of the Children’s Centre (both physically and in the context of its staff) may offer new ways of facilitating and improving innovative collaborations in child and family-focused services. In particular, examples of different forms of embeddedness were identified in the data and a focus on developing and enhancing these specific forms in practice (structural, role, relational, cultural and positional) may provide more structured and attainable ways of embedding the work of Children’s Centres in statutory and voluntary sectors as well as in the wider communities that they serve. This demands human capital inputs and the development of relational capacities across networks that challenge competitive market focused supply approaches commonly associated in mixed economies. This also raises critical questions about the possibilities for innovative and embedded service delivery in the context of increasing national and local austerity measures and in contexts of high staff turnover in some sectors.

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